Louisiana Children's Health Insurance Program (LaCHIP)

is no-cost health insurance for children under age 19.

Ways to Apply

1. **Online** – Apply at www.LaCHIP.org

2. **Mail** – Mail the application and documents of proof to

LaCHIP
P.O. Box 91278
Baton Rouge, LA
70821-9278

3. **Fax** – Fax the application form and documents of proof to **1-877-523-2987 (toll-free)**

4. **Drop Off** – Drop off the application and documents of proof at your local Medicaid/LaCHIP Office. Call **1-877-252-2447** for your local office address.

Income Limits

We count parent's gross income (before deductions). Income limits are based on family size. ***We do not count grandparents or other caregivers in the family size, so their income is not included.***

If your income is above these limits, you may still qualify because we give deductions based on types of income and expenses (such as child support and daycare).

Number in family	Income Limits through March 31, 2010	
	Weekly Income	Monthly Income
1	$451	$1,805
2	$607	$2,429
3	$763	$3,052
4	$918	$3,675
5	$1,074	$4,299
6	$1,230	$4,922
7	$1,386	$5,545
8	$1,542	$6,169
For each extra person, add $600.		

If your income is over these amounts, see the information about LaCHIP Affordable Plan on the back of this flyer.

LaCHIP Covers These Things

- Doctor visits
- Hospital visits
- Dental care
- Vision care
- Hearing care
- Lab work & tests
- Immunizations (shots)
- Prescription medicines
- Medical equipment & supplies
- Medically necessary transportation
- Speech & language therapy
- Physical therapy
- Occupational therapy
- Mental health clinic services
- Psychological tests & therapy
- Help with scheduling appointments

You Choose Your Doctor

You may get care from any doctor or clinic who accepts Medicaid/LaCHIP. Most people must choose one doctor to be their Primary Care Physician.

Other Insurance

If you have or can get insurance through your job, Medicaid may help pay the premiums.
Call 1-866-362-5253 or go online www.LAHIPP.DHH.Louisiana.gov.

Help with Buying Food

Help with buying food (The Louisiana Purchase Card) is decided by another office. Call 1-888-524-3578 or go online www.DSS.LA.gov.

Questions

If you have questions or need help filling out the application, call **1-877-252-2447**.
If you are deaf or hard of hearing and use a TTY text telephone, call **1-800-220-5404.** These calls are free.

LaCHIP Affordable Plan

If your child does not qualify for the no-cost LaCHIP program because of your family's income, he/she may qualify for the ***LaCHIP Affordable Plan***, a low cost program.

The ***LaCHIP Affordable Plan*** has co-payments and a $50 monthly premium to cover all children in the home.

The ***LaCHIP Affordable Plan*** provides different benefits than the LaCHIP services listed on this flyer. Visit www.LaCHIP.org for more information about covered services for the ***LaCHIP Affordable Plan***.

Your Rights

If you think the decision we make is unfair, incorrect, or made too late, you may ask for a fair hearing:

1. Call the LaCHIP office at 1-877-252-2447 OR
2. Write to
   LA DHH Bureau of Appeals
   P. O. Box 4183
   Baton Rouge, LA 70821-4183 OR
3. Call or write to your local Medicaid/LaCHIP office

LaCHIP is an Equal Opportunity Program

Medicaid/LaCHIP cannot treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have, you may:

1. Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 OR
2. Write to:
   LA Dept. of Health & Hospitals
   P. O. Box 4818
   Baton Rouge, LA 70821-4818 OR
3. Call or write to your local Medicaid/LaCHIP office

This public document was published at a total cost of $18,958.50. One hundred thousand (100,000) copies of this public document were published in this first printing at a cost of $18,958.50. The total cost of all printings of this document, including reprints, is $18,958.50. This document was published by Office of State Printing, 950 Brickyard Lane, Baton Rouge, LA 70804 to advise applicants, recipients and other individuals of LaCHIP coverage available through the Medicaid Program under authority of 42 CFR 435.905 (a)(1) and Act 128 of the 1998 1st Extraordinary Session of the Louisiana Legislature. This material was printed in accordance with the standards for printing by state agencies established pursuant to R.S. 43:31. Printing of this material was purchased in accordance with provisions of Title 43 of the Louisiana Revised Statutes.

BHSF Form 1-CH Cover
Rev. 08/08
Prior Issue Obsolete

LOUISIANA
Department of HEALTH and HOSPITALS

Application For

LaCHIP Affordable Plan
Louisiana Children's Health Insurance Program

Low-Cost Health Insurance For Children

Apply online at
www.LaCHIP.org

1+877+2LaCHIP (252-2447)

¿Necesita traductor de español? Llame al 1-877-252-2447.

Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số 1-877-252-2447.

Application For

LaCHIP
Louisiana Children's Health Insurance Program

No-Cost Health Care For Children

Apply online at
www.LaCHIP.org

1+877+2LaCHIP (252-2447)

BHSF Form 1-CH
Rev. 08/08
Prior Issue Obsolete

Interviewer: _____

Date of Interview: _____

Application

Use this application to apply for LaCHIP, LaCHIP Affordable Plan, or Medicaid for children under age 19. You may also apply online at www.LaCHIP.org.

To apply using this application:

1. **Fill it out and sign with a black ink pen.**
2. **Get together the documents of proof we need.**
3. **Mail or fax the form and documents of proof to:**

LaCHIP
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX: 1-877-523-2987

What language do you speak best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other _____
What language do you write best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other _____

Si usted quiere una solicitud en español o quiere hablar con alguien que habla español, llame al 1-877-252-2447.
Nếu quí vị cần đơn tiếng Việt hoặc tham khảo với nhân viên người Việt, Xin gọi số điện thoại miễn phí 1-877-252-2447.

1. Does anyone get Medicaid in another state? ❑ Yes – Who? _____ ❑ No

You cannot get Medicaid benefits in more than one state at the same time. We can help to get your Medicaid closed in another state. You must be a Louisiana resident to get Louisiana LaCHIP or Medicaid.

2. Where did you get this LaCHIP application form?

❑ LaCHIP/Medicaid Office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative ❑ Internet
❑ School Clinic ❑ Food Stamp Office ❑ Health Unit ❑ Business (Store, Work) ❑ Festival/Health Fair
❑ Somewhere else: _____

3. Parent or Caregiver Information (List a second parent or caregiver in Question 4)

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Mailing Address _____
P.O. Box or Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Home Address *(if different)* _____
Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Parish _____ E-mail Address_____

Home Phone (____)_____ Cell Phone (____)_____ Daytime Phone (____)_____

Best Day and Time to Call During our Office Hours (Mon-Fri, 8:00 am – 4:30 pm)_____

4. Does another parent or caregiver live in the home? ❑ Yes – Answer Questions Below ❑ No - Go to Question 5

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Relationship to the person listed in Question #3: ❑ Husband ❑ Wife ❑ Friend ❑ Other: _____

5. List ALL children under age 19 who live in the home. ***Use a separate sheet of paper if more than 4.***

A. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____Date of Birth (month, day, year)_____
Relationship to Person in Question 3: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____
Relationship to Person in Question 4: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more):
❑ White ❑ Black ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ American Indian or Alaska Native – Tribe: _____

Is this child applying? ❑ Yes – Answer the next questions ❑ No – Go to B
Does this child have a disability? ❑ Yes ❑ No If yes, explain: _____
Place of Birth: State (if born in the U.S.)_____Country (if born outside the U.S.)_____
Mother's Name _____
First *(Maiden Name)* *Last*
Is this child a U.S. citizen? ❑ Yes – Go to Question B ❑ No – Answer the next questions
Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____
Permanent Resident Card (green card) Number **A#**_____

B. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____Date of Birth (month, day, year)_____
Relationship to Person in Question 3: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____
Relationship to Person in Question 4: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more):
❑ White ❑ Black ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ American Indian or Alaska Native – Tribe: _____

Is this child applying? ❑ Yes – Answer the next questions ❑ No – Go to C
Does this child have a disability? ❑ Yes ❑ No If yes, explain: _____
Place of Birth: State (if born in the U.S.)_____Country (if born outside the U.S.)_____
Mother's Name _____
First *(Maiden Name)* *Last*
Is this child a U.S. citizen? ❑ Yes – Go to Question C ❑ No – Answer the next questions
Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____
Permanent Resident Card (green card) Number **A#**_____

C. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____Date of Birth (month, day, year)_____
Relationship to Person in Question 3: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____
Relationship to Person in Question 4: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more):
❑ White ❑ Black ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ American Indian or Alaska Native – Tribe: _____

Is this child applying? ❑ Yes – Answer the next questions ❑ No – Go to D
Does this child have a disability? ❑ Yes ❑ No If yes, explain: _____
Place of Birth: State (if born in the U.S.)_____Country (if born outside the U.S.)_____
Mother's Name _____
First *(Maiden Name)* *Last*
Is this child a U.S. citizen? ❑ Yes – Go to Question D ❑ No – Answer the next questions
Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____
Permanent Resident Card (green card) Number **A#**_____

D. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____Date of Birth (month, day, year)_____
Relationship to Person in Question 3: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____
Relationship to Person in Question 4: ❑ Child ❑ Stepchild ❑ Grandchild ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more):
❑ White ❑ Black ❑ Hispanic or Latino ❑ Asian ❑ Native Hawaiian or Pacific Islander
❑ American Indian or Alaska Native – Tribe: _____

Is this child applying? ❑ Yes – Answer the next questions ❑ No – Go to Question 6

Does this child have a disability? ❑ Yes ❑ No If yes, explain: _____

Place of Birth: State (if born in the U.S.)_____Country (if born outside the U.S.)_____

Mother's Name _____
First *(Maiden Name)* *Last*

Is this child a U.S. citizen? ❑ Yes – Go to Question 6 ❑ No – Answer the next questions

Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____

Permanent Resident Card (green card) Number **A#**_____

6. Is anyone pregnant? ❑ Yes – Answer the Next Questions ❑ No – Go to Question 7

Who is pregnant? _____Due Date_____

7. Do any children have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

Which children are covered? _____

Policyholder's Name _____Coverage Start Date_____

Insurance Company Name and Phone Number_____

Policy Number _____Group Number_____

Is this policy through a job? ❑ Yes ❑ No If yes, name of employer: _____

What does the policy cover? ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance ❑ Pregnancy

8. Has health insurance ended for any child in the past 12 months? ❑ Yes – Answer the Next Questions ❑ No – Go to Question 9

Who was covered? _____Coverage End Date: _____

Insurance Company Name and Phone Number_____

Why did coverage end? ❑ Employment ended ❑ Reduced number of work hours ❑ Death of parent ❑ Divorce
❑ Exceeded lifetime maximum ❑ COBRA expired ❑ New employer does not offer dependent coverage
❑ Too expensive – If too expensive, what was the family premium each pay period? $_____
❑ Other reason for insurance ending _____

9. Does anyone work? ❑ Yes – Fill Out Below ❑ No – Go to Question 10

Include all wages or cash received from working, self-employment, and tips.
We do not count the income of grandparents and other non-parent caregivers.

Who Works?	List Employer & Phone # or Write Self-Employed	How Much is Paid? (show gross income, before deductions)	How Often Paid? (weekly, every 2 weeks, twice a month, monthly)	Is Insurance Offered?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

10. Does anyone get money that is not from a job like the kinds listed below?

• Social Security • SSI • Unemployment • Worker's Comp • Money from Friends/Relatives
• Child Support *(list the child as the person who gets it)* • Alimony • Something else *(list below)*

❑ Yes – Fill Out Below ❑ No – Go to Question 11

We do not count the income of grandparents and other non-parent caregivers.

Who gets it?	What is it?	How much?	How often?
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly
			❑ weekly ❑ every 2 weeks ❑ twice a month ❑ monthly

11. Does anyone pay for childcare or care for someone with a disability in order to work or get job training? ❑ Yes – Fill Out Below ❑ No – Go to Question 12

Whose care is paid for? _____ Who pays for the care? _____

How much is paid? _____ How often paid? _____

Is any help received paying it? ❑ Yes – How much? _____ ❑ No

Name of Daycare or Caregiver _____ Phone Number (____) _____

12. Does anyone in your home pay court-ordered child support or alimony? ❑ Yes – Fill Out Below ❑ No – Go to Question 13

Name of Person Who Pays It _____

How much is paid? _____ How often paid? _____

13. Does any child need LaCHIP or Medicaid for the last 3 months because there are medical bills (paid or unpaid) from this time? ❑ Yes – Fill Out Below ❑ No – Go to Question 14

LaCHIP/Medicaid may cover children up to 3 months before they apply if they had medical services during that time.

Who received medical services? _____ In what months? _____

14. Has any child ever received LaCHIP or Medicaid in Louisiana? ❑ Yes – Fill Out Below ❑ No – Go to Question 15

If anyone has received LaCHIP or Medicaid before and still has their plastic Medicaid card, we will re-activate the same card if they qualify again. We will not send a new card unless you tell us to.

Who needs a new Medicaid card? _____

15. If the children are approved for LaCHIP or Medicaid, we will review the case every year. If we need to contact you, how should we reach you? ❑ Telephone ❑ U.S. Mail ❑ E-mail

You should let us know if your contact information changes at any time, even if the change is temporary.

This is the end of the application. SIGN BELOW.

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here: _____ **Date:** _____

Send Your Completed Application to:
LaCHIP
P.O. Box 91278
Baton Rouge, LA 70821-9278

YOUR RIGHTS AND RESPONSIBILITIES
KEEP THIS PAGE FOR YOUR RECORDS

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) if anyone moves into or out of the home; 3) changes in mailing or home address; and 4) changes in health insurance and premiums.

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizen and immigration status given on this form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, you and/or the person(s) applying may get health benefits that you or they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give about you and/or the person(s) applying will be checked. You agree to help do that and let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for you and/or the person(s) applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by you and/or the person(s) applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for you and/or the person(s) applying.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. We will make a referral if the parent(s) gets Medicaid unless Medicaid determines you have good cause not to cooperate with Support Enforcement.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818, Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons who are eligible for Medicaid.

Documents of Proof You May Need to Send Us

If any of these things apply to you and your family, send copies of these documents. Let us know if you cannot get them. We may be able to help.

For all applicants, send copies of health insurance cards (front and back).
For applicants who are not U.S. citizens, send copies of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services.
For children born outside Louisiana, send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital records offices where you may request birth certificates.
For children and their parents, send pay stubs from last month showing gross pay (before taxes) or a letter from the employer. If self-employed, send copies of last year's tax return and all schedule attachments. *Grandparents and other non-parent caregivers do not have to send this information.*
For applicant and their parents, send proof of gross income (before taxes) for all money that is not from a job like Veteran's Benefits, worker's comp, and alimony. Proof could be award letters or 1099 tax statements. *Grandparents and other non-parent caregivers do not have to send this information.*
Proof of child care payments from the day care center. Proof of payments for adult care from the caregiver.
Court order and proof of alimony or child support payments made to persons outside the home. *If it is paid through Louisiana Support Enforcement Services (SES), you **do not** have to send proof – let us know.*
If you are requesting LaCHIP/Medicaid coverage for the three months before you apply, send proof of income for those months.

IMPORTANT PHONE NUMBERS		
	PHONE NUMBER	**TTY TEXT TELEPHONE**
LaCHIP	**1-877-252-2447 1-877-2LaCHIP**	**1-800-220-5404**
KIDMED (EPSDT)	**1-800-259-4444**	**1-877-544-9544**
CommunityCARE (to request a change of Primary Care Doctor)	**1-800-259-4444**	**1-877-544-9544**
KIDMED and CommunityCARE Physician Referral Assistance	**1-877-455-9955**	
Medicaid Services	**1-888-342-6207**	
Office of Group Benefits (for LaCHIP Affordable enrollees)	**1-800-272-8451**	
Transportation (to request non-emergency transportation)	**1-800-259-1944**	

IMPORTANT WEB SITES	
LaCHIP	**www.LaCHIP.org**
LaMOMS – Medicaid for Pregnant Women	**www.LaMOMS.DHH.Louisiana.gov**
Other Medicaid Programs	**www.Medicaid.DHH.Louisiana.gov**
Find a Doctor Who Accepts Medicaid	**www.La-CommunityCare.com**
KIDMED & CommunityCARE	**www.La-KidMed.com**
Apply for or Renew Your Medicaid	**www.Medicaid.DHH.Louisiana.gov**
Office of Group Benefits (for LaCHIP Affordable enrollees)	**www.GroupBenefits.org**

KEEP THIS PAGE FOR YOUR RECORDS